# Personal Care Services

**Definition**: Active, hands-on assistance in the performance of Activities of Daily Living (ADL's) or Instrumental Activities of Daily Living (IADL's) provided to the waiver participant in his/her home. This service may only be provided in other locations when defined in the Support Plan. ADL's include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, and assistance with ambulation. If it is determined that a participant requires more than one personal care aide, this must be prior-approved by DDSN and documented on the Support Plan. IADL's include light housework, laundry, meal preparation and shopping. These IADL activities are for the specific needs of the participant, not the general needs of the household. IADL's may also include home safety, assistance with communication, medication monitoring – to include informing the participant that it is time to take medication prescribed by his/her physician or handing the participant a medication container – and limited assistance with financial matters, such as delivery of payments as directed by the participant on his/her behalf.

Authorizations to providers will be made at two different payment levels. Based on DDSN assessed need, the higher level service, Personal Care 2, may be considered appropriate when the care needed for assistance with ADL's alone or in conjunction with assistance with IADL's/home support. Based on DDSN assessed need, the lower level service, Personal Care 1, may be considered appropriate if the only needed care is for IADL's/home support activities. PC 1 does not include hands-on care.

Personal Care 2 services may include escort and transportation when necessary. This must be specifically documented on the Support Plan; there must be no other resources available; and, the provision of transportation will depend upon the personal care provider's policy in this regard.

Personal Care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide except as allowed by the Nurse Practice Act and prior-approved by a licensed physician. The Nurse Practice Act is available on the following web page: http://www.scstatehouse.gov/code/t40c033.htm

Both services allow the provider to accompany the participant on visits in the community when the visits are related to the needs of the participant, specified in the Support Plan, and related to needs for food, personal hygiene, household supplies, pharmacy or durable medical equipment. The Service Coordinator has the responsibility to identify the necessity of the trip, document the Support Plan, authorize this component of the service, and monitor the provision of the services.

**A Personal Care Aide is not allowed to render services in a school setting.**

The unit of service is 15 minutes, provided by one Personal Care Aide (PCA).

Please see: Scope of Services for Personal Care 1 (PC I) Services
Scope of Services for Personal Care 2 (PC II) Services

**Service Limits:** For adults (age 21 and over), Personal Care 2 Services are limited to a maximum of 28 hours (112 units) per week, as determined by SCDDSN assessment. A week is defined as Sunday through Saturday. When Personal Care 2 is authorized in conjunction with Adult Attendant Care and/or Adult Companion Services, the combined total hours per week of services may not exceed 28. Unused units from one week cannot be banked for use during a later week.

For adults (age 21 and over), Personal Care 1 Services are limited to a maximum of 6 hours (24 units) per week, as determined by SCDDSN assessment.

For children (under age 21), Personal Care Services are covered as part of the Medicaid State Plan. The Service Coordinator will authorize these State Plan services; however, the service limits imposed by the MR/RD Waiver will not apply. The Service Coordinator must re-authorize Personal Care Services through the MR/RD Waiver when the participant turns 21. At that time, the service limits will apply.

Participants receiving Residential Habilitation may not receive Personal Care (1 or 2) Services through the MR/RD Waiver.

**Providers**: Personal Care Services must be provided to participants by an agency contracted with the Department of Health and Human Services.

Agencies contracted with the Department of Health and Human Services must adhere to the requirements noted in the Scope of Services for Personal Care Services (1 and 2) for the MR/RD Waiver, which specifies the minimum qualifications for a PCA 1 and for a PCA 2.

**Arranging for and Authorizing Services**: The need for the service must be documented in the participant's Support Plan. To assess the need for Personal Care Services, the Service Coordinator must complete the Personal Care/Attendant Care Needs Assessment (MR/RD Waiver Form 34). The Support Plan must also include documentation of the amount and frequency of the service. Personal Care Services (I or II) are approved at the local level. **Service Coordinators will not key or include Personal Care Services in the Waiver budget for children under the age of 21.**

The participant/family should be given a listing of available providers from which to choose. This offering of provider choice must be documented. Once the service is approved and an agency is selected, the Service Coordinator should complete the Authorization for Personal Care Services (MR/RD Form A-3) and send a copy to the chosen agency. This authorization remains in effect until a new/revised Authorization for Personal Care Services (MR/RD Form A-3) is sent or until services are terminated (see Chapter 8). **For children under the age of 21, a physician's order must be obtained and attached to the authorization**. The Physician's Order for Personal Care Services (MR/RD Form 15) may be used for this purpose.

**Monitoring Services:** The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Personal Care Services (1 and 2):

- During the first month of service, monitoring should be conducted while the service is being provided, unless the Service Coordination Supervisor documents an exception. An exception can only be made when the service is provided in the late evening or early morning hours (between 9:00 pm and 7:00 am).
- Services should be monitored at least once during the second month of service.
- Services should be monitored at least quarterly (i.e. within 3 months of the previous monitoring) thereafter.
- Monitoring should start over as if it is the start of service any time there is a change of provider.
- Monitoring should be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).
- Monitoring must be conducted by contact with the participant/family. It can be supplemented with contact with the service provider.
- Review the daily logs completed by the aides during on-site visits.
- Monitoring of the participant's health status should always be completed as a component of Personal Care monitoring.

Some questions to consider during monitoring include:

- Is the participant receiving Personal Care services as authorized?
- Does the PCA show up on time and stay the scheduled length of time?
- Does the provider show the participant courtesy and respect?
- Has the participant's health status changed since your last monitoring? If so, does the service need to continue at the level at which it has been authorized?
- Is the participant pleased with the service being provided, or is assistance needed in obtaining a new provider?
- What kinds of tasks is the PCA performing for the participant?
- If the PCA does not show up for a scheduled visit, who is providing back-up services?
- Who is providing supervision of the PCA? How often is on-site supervision taking place?

**Reduction, Suspension or Termination of Services:** If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

# Mental Retardation/Related Disabilities Waiver
# Personal Care (PC 1 and PC 2)/Attendant Care Needs Assessment

**MR/RD Waiver Participant:** _____

**Social Security Number:** _____

**Age:** _____ **Service(s) Requested** ☐ PC 1 ☐ PC 2 ☐ Attendant Care

## I. Personal Care Needs/ Assistance Required/ Frequency and Time Required

| | | |
|---|---|---|
| Bath: Bed ☐ Shower/Tub ☐ | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| Shaving: | Partial ☐ Total ☐ | __ X Daily, 15 Min ☐ Other _____ |
| Oral Hygiene: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Skin Care: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Dressing and Grooming: | Partial ☐ Total ☐ | __ X Daily, 15 Min ☐ Other _____ |
| Incontinence Care: | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| Toileting: | Partial ☐ Total ☐ | __ X Daily, 15 Min ☐ Other _____ |
| Positioning and Turning in Bed: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Medication Monitoring: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Other Medical Monitoring: | | |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| Exercise | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| Transfers: | | |
| Hoyer ☐ | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Sliding Board ☐ | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Lift System ☐ | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Other _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| Other Personal Care Needs: | | |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |

## II. Meal and Dining Needs

| | | |
|---|---|---|
| **Preparation and Set-Up** | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| **Dining** | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| **Clean Up** | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |

## III. General Housekeeping Needs (not appropriate for children under the age of 12)

Vacuuming Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Sweeping Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Dusting Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Mopping Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Cleaning Participant's Bathroom: __ X Weekly, 30 Min ☐ Other _____

Cleaning Participant's Bedroom: __ X Weekly, 15 Min ☐ Other _____

Participant's Laundry: __ X Weekly, 90 Min ☐ Other _____

## IV. Other Needs

Shopping Assistance*: Errands __ X Weekly, 60 Min ☐ Other _____

Escort __ X Weekly, 60 Min ☐ Other _____

*__not appropriate for recipients under age 21__

Assistance with Communication: __ X Weekly, 60 Min ☐ Other _____

## V. Requested Schedule for Personal Care or Attendant Care Services

***Sunday***

***Monday***

***Tuesday***

***Wednesday***

***Thursday***

***Friday***

***Saturday***

Total Units of Personal Care 1 *requested* (by the participant/caregiver/representative) per week: _____

☐ **Total Units of Personal Care I recommended (by the Service Coordinator) per week:** _____

Total Units of Personal Care 2 *requested* (by the participant/caregiver/representative) per week: _____

☐ **Total Units of Personal Care 2 recommended (by the Service Coordinator) per week:** _____

Total Units of Adult Attendant Care *requested* (by the participant/caregiver/representative) per week: _____

☐ **Total Units of Adult Attendant Care recommended (by the Service Coordinator) per week:** _____

Include justification for or against requested number of weekly units: _____

_____ _____

**Signature of Person Completing Assessment** **Title**

_____

**Date**

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**
**MR/RD WAIVER**

**AUTHORIZATION FOR PERSONAL CARE SERVICES**
***TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES***

**TO:** _____

***You are hereby authorized to provide*** ☐ **Personal Care I (S5130)** ☐ **Personal Care II (T1019)** ***for:***

**Participant's Name:** _____ **Date of Birth:** _____

**Address:** _____
_____
_____

**Phone Number:** _____ **Medicaid #:** _____ **Social Security #:** _____

***Only the number of units rendered maybe billed. Please note: This nullifies any previous authorization to this provider for this service(s).***

**Prior Authorization #** _____

**Start Date:** _____

**Authorized Total – PC I** __ **Units per week (no more than 24 for adults age 21 and over; 1 unit = 15 minutes)**

**Authorized Total – PC II** ___ **Units per week (no more than 112 for adults age 21 and over; 1 unit = 15 minutes)**

**Service Tasks Requested:**

☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
☐ Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
☐ Assistance with exercise, positioning, etc.
☐ Escort services

**Please note: Physician's order must be attached for participants under age 21. MR/RD Form 15 may be used.**

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____
_____

Phone #: _____

_____ _____
Signature of Person Authorizing Services Date

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**
**MR/RD WAIVER**

# PHYSICIAN'S ORDER FOR PERSONAL CARE SERVICES

**Participant's Name:** _____ **Date of Birth:** _____ **Social Security #:** _____

I hereby order Personal Care Services to be rendered to the above named participant.

Physician's Name: _____

Address: _____
_____
_____

Phone #: _____

_____ _____
Physician's Signature Date